DC Child and Family Services Agency
Quality Improvement Administration
400 6th Street, SW
Washington, DC 20024
202-442-6000 www.cfsa.dc.gov




Quality Assurance Report ê June 2007

Contents

Executive Summary

During the past six months, the DC Child and Family Services Agency (CFSA), Court Monitor, and *LaShawn* Plaintiffs submitted an Amended Implementation Plan (AIP) under the *LaShawn* lawsuit to the Federal Court. Consistent with CFSA's continued focus on quality, the AIP reflects a shift in reform to emphasize quality practice. CFSA also launched several initiatives to improve overall quality of practice. For instance, the agency has implemented a protocol for listening to recorded calls to the hotline for training purposes, established a joint CFSA-Healthy Families/Thriving Communities Collaborative committee to develop a model for in-home practice, and restructured out-of-home units to imbed permanency planning social workers to focus on permanence from the onset of removals into foster care.

CFSA conducted several evaluations and assessments to better understand quality of practice and performance outcomes. For instance, to further understand the issue of multiple placements, CFSA analyzed placements of female adolescents. We also conducted a quantitative assessment of the quality of services provided to children and families involved in in-home cases and evaluated the early stages of the permanency redesign to assess the change process and outcomes of change. CFSA prepared an initial draft of a Mental Health Needs Assessment to identify the mental and behavioral health needs of children and youth in out-of-home care and to recommend ways to enhance collaboration with the DC Department of Mental Health. This report concludes with agency-wide recommendations for further improving our case practice system.

Introduction

In February 2007, CFSA, the Court Monitor, and *LaShawn* Plaintiffs submitted an Amended Implementation Plan (AIP) under the *LaShawn* lawsuit to the Federal Court. Following extensive negotiations, the District of Columbia and Plaintiffs agreed to a new framework for achieving outcomes required to exit *LaShawn* and to extend the deadline for improving the District's child welfare system until December 31, 2008.[1] Consistent with CFSA's continued focus on quality, the AIP reflects a shift in reform from merely complying with quantitative measures to instituting quality practice throughout CFSA and in tandem with our partners. Designed in part to spur CFSA to continue to examine practice to learn from achievements and shortfalls, the AIP delineates goals, outcomes, and strategies in three sections: (1) outcomes to be achieved to ensure child safety, permanency, and well-being and system accountability; (2) outcomes to be maintained (i.e., areas where CFSA has reached compliance and must sustain performance); and (3) strategies and action steps to achieve outcomes in critical areas, including investigations, placements, visits, case planning, and health and mental health services. The AIP stipulates both qualitative and quantitative standards to drive quality practice and performance and to secure better outcomes for children.

Other AIP highlights include:

- Lower maximum caseloads for CFSA and private agency front-line staff, including investigators, in-home and out-of-home social workers, and permanency specialists.
- Specification of standards that constitute quality investigations of abuse and neglect.
- Standards for quality visits to children and families, including clear mandates for social workers and case managers to assess the safety of all children at every visit and to use Structured Decision Making™ to assess safety and risk throughout the life of cases.
- Requirements to reduce multiple placements for children and youth in foster care and to provide interventions and services that promote placement stability.
- Practices to cultivate family-centered decision-making throughout case planning.
- Standards to achieve permanence for children and youth more effectively and swiftly.

Following the Federal Court's February approval of the AIP, CFSA immediately instituted several processes to gauge progress and performance. We created a comprehensive monitoring document that identifies AIP goals, action steps, deliverables and outcomes, lead staff, and status updates. Due dates and timeframes are attached to all deliverables. Intended to ensure vigorous self-monitoring and accountability, lead staff report on the progress of their assigned tasks and add status updates to the document every two weeks. The document is continually circulated

[1] The original Implementation Plan (IP) date was December 31, 2006. Although the District failed to meet improvement measures of the IP, progress was sufficient to warrant a new AIP with additional timeframes.

among lead staff and reviewed at executive-level meetings to ascertain progress in fulfilling AIP requirements and enhancing overall case practice. Together, the AIP and CFSA's Practice Model oblige all agency staff to ensure steady improvement in providing quality services and achieving performance outcomes.

To track and present client and performance trends more effectively, CFSA is revising the Monthly Trend Analysis to align it with new requirements and performance measures under the AIP; incorporate a strengthened analytical perspective; and more fully address the entire service population of children both at home and in out-of-home care. We continue to disseminate the Monthly Trend Analysis among staff, the Court Monitor, and other external parties.

In addition to the performance-driven tracking methods, CFSA has submitted a Continuous Quality Improvement (CQI) plan to the Court Monitor for review and approval. It outlines a CQI system that will incorporate periodic review, measurement, evaluation, and support for agency services and positively affect the lives of children and families we serve. The system will focus on safety, permanence, and well-being outcomes for children and families; adherence to local, Federal, and judicially mandated requirements; and development, implementation, and refinement of the Practice Model, which engages families, is grounded in knowledge of the community and culture, uses teamwork strategies consistently and effectively, and is driven by a sense of urgency around permanence.

The CQI system will propel efforts to:

- Accomplish key outcome and service goals for children and families, consistent with the Practice Model, AIP requirements, and Federal standards.

- Provide timely, quality information to senior management, each program area, individual supervisory units, external stakeholders, and the community at large regarding strengths and challenges of practice and outcomes.

- Support CFSA as a learning organization, ensure a steady flow of information, promote a culture of improvement rather than blame, and establish clear processes for accountability.

- Engage external stakeholders (such as children/youth, families, and private agencies) and CFSA staff, supervisors, and managers in quality improvement and ensure that the use of information and approaches to assessment support improvement of practice and outcomes.

- Build the right mix of quantitative and qualitative information to answer key questions about practice and outcomes.

- Engage key partners and constituents in the quality improvement process to enhance their understanding of child welfare issues, particular strengths and challenges in local practice, and their own role in improving practice and outcomes.

The cornerstone of CFSA's CQI approach is to have internal and external stakeholders at all levels participating in a process that supports a system of transferring knowledge and establishing a learning environment. In turn, the approach will enhance case practice and development of policy and procedures. So that there is a continuous feedback loop of information that leads to action, CFSA will share findings from the CQI process with senior and middle management for decision-making as well as with supervisory and front-line staff for training and learning. We will also share appropriate quality improvement information with a wide range of external partners to encourage community-wide learning and improvement.

In June, Mayor Fenty nominated a permanent Director for CFSA, who is now awaiting District Council confirmation. In the past four years, CFSA has had four leaders. CFSA needs leadership stability to stay the course in meeting the AIP's rigorous standards and sustaining performance gains.

Evaluative Reports Cite CFSA's Performance Achievements

Several recent evaluative reports from CFSA or independent sources describe child welfare progress and performance.

Council for Court Excellence Report: On January 31, 2007, the Council for Court Excellence (CCE) released its third progress report on child welfare system reform in the District. The bi-annual report stated, "The D.C. child welfare system is vastly improved since CCE began measuring its performance in 1999. It is now in nearly full compliance with the several federal and D.C. laws under which it operates, though some serious performance challenges remain." CCE focuses on performance and coordination among CFSA, the District of Columbia Superior Court Family Court, and the District's Office of the Attorney General. The report cites the availability of reliable performance data from all three entities as one of the foremost system achievements of the past two years. It notes that reducing the time in foster care for most children remains a serious challenge and recommends that the District should continue to regard prompt permanence as an "important governmental priority" and strive to identify and overcome impediments.

CFSA Report on ASFA Compliance: CFSA annually prepares a report to inform the Mayor, City Council, and public of District achievements and challenges in meeting requirements of the Federal Adoption and Safe Families Act (ASFA). This year's report revealed CFSA has improved compliance with various ASFA measures.

Achievements included expeditious investigation and adjudication of abuse/neglect reports, timely development of case plans, and improved CFSA and Family Court timeliness in approving children's permanency plans and holding permanency hearings. According to the report, CFSA has faced several challenges in meeting ASFA requirements, including closing gaps in children's mental health services, creating sufficient foster and adoptive families, and collaborating effectively with District and Maryland public school systems.

Abuse/Neglect Prevention Inventory: In response to legislation enacted by D.C.'s City Council, CFSA's Office of Planning, Policy, and Program Support assessed child abuse and

neglect prevention (CAN) programs in the District and analyzed service gaps. The assessment identified a wide range of programs that support children and families, all of which either address CAN risk factors or include CAN prevention. It noted several gaps in local prevention services, including lack of evidence-based approaches to CAN prevention and a shortage of basic necessities that support family life, such as employment and safe, affordable housing. The assessment recommended legislation to mandate development of a comprehensive, adequately resourced CAN prevention plan; coordination of CAN prevention efforts with early-childhood and youth-relative initiatives; and dedication of resources to maintain an inventory of effective CAN prevention programs.

CFSR Statewide Assessment: In preparation for the District's second Federal Child and Family Services Review (CFSR)[2], CFSA convened a team to facilitate community input into the CFSR and prepare the required Statewide Assessment. It features detailed narrative assessments of seven safety, permanence, and well-being outcomes and associated indicators for each outcome. It summarizes the policy, practice, performance, strengths, challenges, and promising practices for each indicator and, when pertinent, compares CFSA outcome data with national standards. Among other findings, the Statewide Assessment revealed:

- The national standard for absence of abuse/neglect in foster care for a 12-month period is 99.68% or more. In FY 2005, the District measured just .02% shy of this standard with 99.66% of children not experiencing abuse/neglect in foster care.

- Federal standards view continuity of family relationships and connections as an important permanency outcome. CFSA policy dictates that we do not routinely place children more than 25 miles outside the District. As of March 31, 2007, 1,164 of CFSA's 2,292 children in foster care were in Maryland (with most of those in homes in Prince George's County, no more than 35 miles from the District); 28 in Virginia; and the remaining count in the District. Fewer than 100 were placed more than 100 miles from the District. The majority of children placed in Maryland are just across the District line with relatives or are in close proximity to relatives residing in the District. Challenges include interstate restrictions on emergency placements with families living outside the District and regulations in Maryland and Virginia that affect foster/adoptive recruitment and timely placements.

- Number of children in care visiting monthly with their siblings more than doubled from 26.8% in December 2003 to 62.8% in March 2007. While twice-monthly visit rates remain relatively low, performance increased 24.3% between March 2006 (25%) and March 2007 (49.3%). Obstacles to foster child-sibling visits include consistent visitation opportunities, accessibility of creative venues for visits, and affordability of agency-sponsored events.

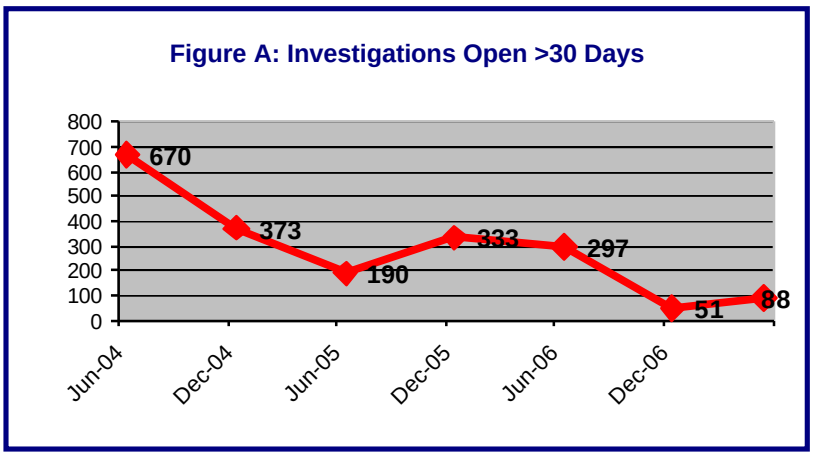
[2] The Federally administered Child and Family Services Review occurred during the last week in June. Results will be included in the December 2007 Quality Assurance Report.

Program Operations

First Half of 2007 Emphasizes Agency-wide Learning and Self-evaluation

CPS Bolsters Training and Continuous Learning

In the first half of 2007, Child Protective Services (CPS) developed a quality assurance practice for the District's child abuse/neglect hotline system and took preliminary steps to design a comprehensive training curriculum for investigators. Going forward, CPS needs to implement a core training and staff development program to enhance investigator and supervisory knowledge, skills, and critical thinking and to conduct grand rounds to assess the quality of investigative practice and identify systemic challenges.



CPS continues to maintain a backlog of fewer than 100 investigations, which is significantly lower than historic levels (Figure A).[3] CPS continues to strive to meet the court-ordered standard that investigators carry no more than 12 investigations at any time. As of April 2007, 52 investigators had 12 or fewer investigations; six were carrying 13 to 16.[4]

CPS must initiate investigations of alleged abuse/neglect promptly. By December 30, 2005, the goal in the *LaShawn* Implementation Plan was to initiate 100 percent of investigations within 48 hours. During April 2007, CPS was at 90 percent performance against this standard.[5]

In April 2007, CPS developed a quality assurance protocol to assess the quality of service at the hotline. The Hotline Recording System, implemented in March 2006, provides "checks and balances" capability to assess appropriateness of calls and accuracy of information received. CPS also uses it as a training tool to ensure staff practices optimum customer service standards, responds efficiently, and gathers pertinent information from callers. Effective May 2007, the hotline supervisor and staff began listening to recorded incoming calls during supervision and evaluating the quality of information gathered from reporting sources. Hotline staff reviews recordings to critique themselves and to obtain supervisory feedback on strengths and challenges

[3] Source: FACES Management Report INV038MS
[4] Source: FACES Management Report INV068MM
[5] Source: FACES Management Report INT001MS. This standard includes both attempts and actual contacts. The AIP has defined the activities that constitute good faith efforts for attempts. A forthcoming assessment of the quality of investigations, which is discussed below, will evaluate CPS' documentation of good faith efforts.

in soliciting and documenting information from reporters and determining the priority of reports. Supervisors also assess recorded calls to identify the information needs of mandatory reporters, such as school teachers, and refine public trainings that CPS conducts to educate mandatory reporters on how to make reports as specific, thorough, and accurate as possible. Going forward, CPS hotline Supervisors, Program Managers, the CPS Administrator, and Deputy Director of Program Operations will also listen to randomly selected calls monthly.

In June 2006, CPS launched a twice-daily screening panel of cross-agency representatives to review hotline reports and accept those appropriate for investigation. The AIP requires CFSA to maintain the panel. CPS has not analyzed trend data of panel decisions; however, CPS supervisors and managers have observed that the panel's screen-in decisions generally correspond with hotline decisions. In some instances, however, the panel has overridden the automated decision tool for screen-out because a hotline worker collected insufficient information at the time of the initial call or made data entry errors. Although not a pervasive problem, instances of failing to screen-in some reports have highlighted an area for continuous training of hotline staff to refine their skills in taking reports and accurately completing the screening tool.

CPS has found the panel to be an educational and training tool for both CPS and non-CPS staff. In discussing reports, panel members review investigative policy and procedures as well as child and family needs hotline staff has documented. Panel members, which have included the agency's substance abuse and housing specialists, In-Home & Reunification staff, and Collaborative representatives, also recommend strategies investigators can use to ensure quality investigations and to identify services and resources for immediate sharing with families.

The AIP requires CPS to implement a core child protective services training curriculum by the end of 2007. In April, CPS met with the Office of Training Services (OTS), Quality Improvement Administration (QIA), and several other CFSA units and administrations to strategize a training and staff development plan. The multi-disciplinary group identified several priority training needs for CPS staff, including critical thinking in child welfare assessment, forensic interviewing skills for the Special and Institutional Abuse Units, and conducting investigations in which children are at risk of removal. OTS is holding discussions with vendors for the first two of these training areas and developing the content and format for the third. OTS anticipates introducing critical thinking training for all CFSA managers in July/August 2007, and the forensic interviewing training in September 2007, as well as implementing additional training based on practice challenges identified in a forthcoming assessment of the quality of investigations (discussed below).

To develop a core curriculum for CPS, the Office of Planning, Policy, and Program Support is researching child protective curricula in jurisdictions across the nation. OTS will assist CPS in identifying the best curriculum to meet CPS staff information and skill needs. In the meantime, CPS continues to receive training in several targeted areas, including collaborative trainings with the Metropolitan Police Department's (MPD) Youth Investigation Branch and the Child Advocacy Center on enhancing teamwork and conducting joint investigations.

CPS is updating Hotline and Investigations policies to clarify standards and procedures. Clarifications will better guide staff in taking thorough abuse and neglect reports and conducting timely, comprehensive, quality investigations.

To further drive quality practice, in February, the Center for the Study of Social Policy (CSSP) and CFSA initiated an assessment of investigative practice in CPS. The assessment, which follows up on a joint CSSP/CFSA investigations study in 2006, has three components: (1) CSSP-conducted focus groups with internal and external stakeholders, including CPS investigators, CPS supervisors and managers, Family Court judges, members of law enforcement, and community members; (2) a case record review of 40 randomly selected investigations that closed in March 2007, by CFSA's Quality Improvement Administration (QIA); and (3) initiation in May of a series of grand rounds to stimulate in-depth discussion among CPS, QIA, and CSSP on the strengths and challenges of several selected investigations.

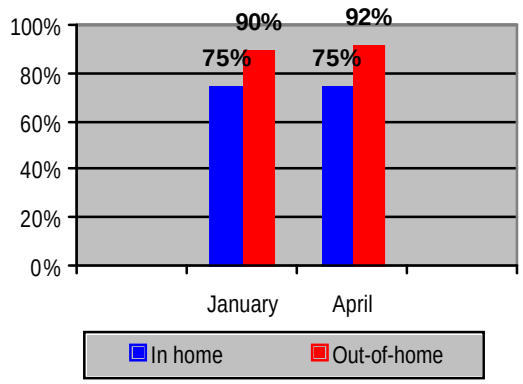
Recommendations:

- *Document and analyze results of listening to recorded hotline calls to identify trends and areas for practice improvement.*
- *Conduct a monthly analysis of results from the screening panel.*
- *Institutionalize monthly grand rounds, involving both CPS and non-CPS staff, to review the quality of investigations and promote continuous improvement and ongoing learning within CPS.*

Family-Centered Efforts Become Fundamental to Quality Practice

CFSA assessed the quality of practice with families served by In-Home Units and continued work with the Collaboratives to develop joint standards for in-home practice. CFSA also made progress in instituting family-centered practices in assessment, case planning, team meetings, and decision-making.

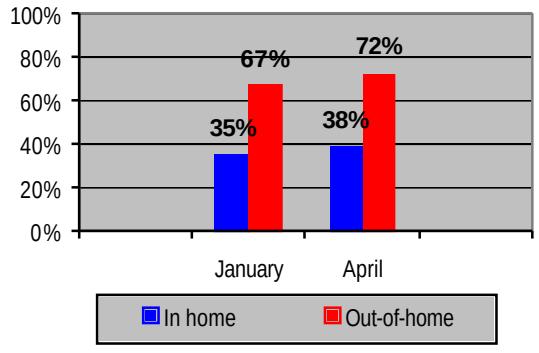
Figure B: One Monthly Social Worker Visit, 2007



Social Worker Visits: In April, CFSA sustained the frequency of monthly social worker visits to children as compared to January 2007. Twice-monthly social worker visits to children in foster care increased from January to April. Monthly visits to children at home remained the same while twice-monthly visits increased slightly

(Figures B and C). In the past six years, CFSA has made significant progress in having social workers visit children at least twice a month (Figure C).[6] In 2002, the Court Monitor reported that only two percent of children in foster care had bi-weekly visits from their social workers in May 2001.[7]

Figure C: Two Monthly Social Worker Visits, 2007

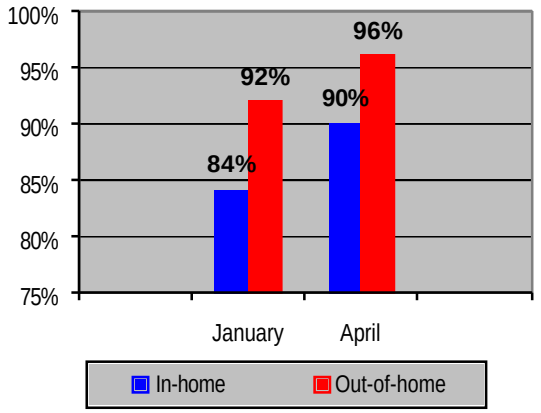


The AIP has clarified standards for visits in that at least one monthly visit must occur at the child's residence. Previously, CFSA counted any face-to-face contact wherever it occurred, as reflected in the data presented here. CFSA is currently considering options to modify the logic behind FACES management reports to reflect the new standards.

To ensure visits are of quality, CFSA and the Collaboratives are completing standards that illuminate activities and outcomes associated with quality visits. Although these standards are part of the joint In-Home Practice Model, many of them are applicable to out-of-home visits and can serve as a template for out-of-home social workers.

CFSA Must Focus on Quality Case Planning: Development of current case plans increased in April compared with January 2007, particularly for children in foster care (Figure D). CFSA must achieve 100 percent compliance with case plan development for in-home and out-of-home cases. The AIP further requires CFSA to develop quality case plans jointly with families and with foster youth. The agency's Family Team Meeting (FTM) Unit and Office of Training Services are developing strategies to improve case planning, including incorporating FTM plans into case plans and training social workers how to team with families to develop and implement individualized, strengths-based case plans.

Figure D: Current Case Plans, 2007



Evaluation of the Quality of In-Home Practice: To assist CFSA in identifying a baseline of in-home case practice, in FY 2007, Quality Assurance (QA) conducted a quantitative assessment of the quality of services provided to children and families at home. The goal was to determine the quality of social workers' assessments of family needs and connection of families to needed services. QA reviewed 25 random cases opened with In-Home as of July 31, 2006. QA examined documentation in FACES and hard-copy case

[6] Source: FACES Management Reports CMT165 and CMT166

[7] September 30, 2002 *LaShawn A. v. Williams* Monitor's Report: Progress in Meeting Probationary Period Performance Standards for the District of Columbia Child and Family Services Agency.

records, and held a focus group with In-Home supervisors.

Preliminary findings reveal that In-Home social workers generally connected families to services and supports that met tangible needs, including clothing, furniture, housing, GED programs, and day care or pre-school programs. Social workers developed professional helping relationships with families that centered on meeting concrete needs. Families appeared to communicate with their social workers and did not turn them away during visits; social workers, in turn, appeared to be accessible to families.

On the other hand, in-home practice lacked a clinical focus. Practice challenges included conducting regular, clinically-based assessments of family behaviors and underlying conditions; understanding the complexity of issues that affected family functioning; and recommending clinically directed services and supports. In addition, social workers did not consistently conduct and document risk assessments, address the needs CPS originally identified during investigations, or follow up on service delivery. For example, although QA found that social workers identified many services for families, case documentation often did not reflect whether social workers actually referred or recommended the services; noted service provider information; or monitored family participation in services. Documentation likewise inconsistently captured whether families benefited from or were satisfied with services.

During the focus group with In-Home supervisors, QA learned that CFSA's practice of geographically assigning cases has facilitated greater social worker knowledge of and sharing about community and neighborhood-based resources available to families outside formal CFSA channels. Supervisors reported that the Structured Decision Making™ tools are useful in guiding case decision-making and case planning. They stated that social workers can delve more deeply into cases and offer them more time, interventions, and services as a result of CFSA's 2006 establishment of discrete units that serve either in-home or out-of-home cases. They also noted that in-home practice has historically focused on providing concrete services and expressed their hope to adopt a more clinically-oriented approach to their casework.

Focus group members described challenges social workers often encounter when serving families in their homes, particularly when family issues include mental health problems, parental substance abuse, educational neglect, and children or youth with severe behavioral issues. They stated the lack of a sufficient mental health service array is a barrier to fully serving families. They noted challenges in engaging families who refuse services or do not followthrough on recommendations. Supervisors stated it is often difficult to engage families in which parental substance abuse is present. They described the need for an effective, systems-wide process for partnering with D.C. Public Schools to address truancy. They noted lack of an active, comprehensive Persons in Need of Supervision (PINS) program limits efforts to assist families in caring for children with significant behavioral problems.

Based on the assessment results, QA's recommendations include: (1) at the onset of case opening, the In-Home social worker should conduct a comprehensive clinical assessment of the family's needs and such assessments should continue throughout the duration of the case; (2) the identification of family needs should go beyond basic case management and should relate to the

reasons a case was opened for abuse/neglect; (3) and social workers should consistently monitor and evaluate families' participation in services, and document this information accordingly.

Joint In-home/Collaborative Practice Model: CFSA and the Collaboratives have established a committee to develop a standard for in-home practice and to guide social workers in their approach and interactions with families. To adapt in-home practice that is more community based, CFSA is moving toward co-locating In-Home staff with the Collaboratives. Planning committees for these two initiatives—the CFSA in-home model and co-location—merged in late 2006 to develop a joint In-Home Practice Model for CFSA and the Collaboratives.

The Joint In-Home Model Committee has developed several products that address practice with families whose children remain in the home, including a conceptual framework; program logic model of the family- and system-level outcomes sought; prioritized indicators and instruments for measuring progress; a practice protocol to guide work with families; and an initial plan for the types of training staff will need to practice community-based, family-centered work. In addition to planning the joint Practice Model, the group has continued to plan for co-location with the Collaboratives. This has included the Collaboratives identifying and acquiring additional office space and CFSA determining unit assignments to the Collaboratives. The AIP requires development and implementation of the joint in-home model in June 2007. CFSA has developed the model and begun planning implementation with staff training and other activities, such as retreats and meetings with Collaborative staff. Physical co-location with the Collaboratives is scheduled to begin in October 2007.

Levels of Care Target Child Needs: CFSA's Levels of Care initiative aims to establish consistent standards for determining foster care stipends, to identify children's special needs and gaps between those needs and services foster parents provide, and to capture data about children's functioning over time. The Office of Organizational Development and Practice Improvement (ODPI) and Business Services Unit completed research to implement the Child Needs-Provider Intervention Assessment (CNPI), a specialized evaluation instrument for ensuring that foster parents receive board rates tailored to children's individual medical, mental health, behavioral, educational, and other needs. The CNPI includes 17 areas of child functioning and foster parent support. Social workers and foster parents jointly select the level that best describes the child's functioning and the kind of support a foster parent provides to meet the child's needs.

To test the accuracy of the assessment process and determine implementation requirements, CFSA sampled a population of foster children and received completed CNPI assessments for 127 of them. CFSA has scored the assessments, entered them into a database, and is now analyzing them. Next steps include ranking assessments by the level of care each child needs, incorporating variables such as length of time in care and number of placement changes, and developing a formula to calculate foster care payment rates. CFSA will then determine staffing needs for implementation of the approach, identify data management implications for FACES, and train social workers and foster parents in using the CNPI tool.

The AIP requires CFSA to implement the CNPI tool with CFSA foster parents by the end of summer 2007 and with private agency foster parents by October 2008. In addition to improving identification of children's needs, refining how we match children with foster placements, and

providing greater equity in foster care payments, CFSA anticipates the CNPI tool will generate a new source of data on child functioning and effectiveness of foster parents. Over time, as we get better at identifying and understanding children's needs, we expect data will show that children are stabilizing and improving in foster care. In instances when children do not stabilize or improve, CFSA will be able to analyze how their needs have changed over time and take steps to better address those needs. CFSA likewise anticipates data collected will provide information about foster parent skills in meeting children's needs, and reveal foster parent needs for additional support or training.

Permanency Strategies Emphasize Expedience and Quality

Total number of children receiving CFSA services decreased from 7,731 in June 2003, to 4,718 in April 2007. Although the number of children in foster care declined by nearly 26%, in that same period, children in out-of-home care as a percentage of overall caseload increased nine percent (Table 1).

Table 1: Children in Care as Percentage of Total Children Served

	June 2003	April 2007
Total children served	7,731	4,718
Children in out-of-home care	3,250 (42%)	2,413 (51%)

Source: FACES CMT252MM

Almost 75 percent of children in foster care in April 2007, had been away from home for two years or fewer (Figure E). However, more than 25 percent had been in care for three years or more.[8] CFSA continues to fall below national standards for achieving timely adoptions.

Compared to the national median with timeliness of adoptions of 32.4 months in fiscal year 2004, CFSA had a median of 41.8 months for fiscal year 2006. Although we were below the national median, we have improved performance in timeliness of adoptions since fiscal year 2005.

Proportion of children with a goal of adoption in pre-adoptive homes declined over the past two years—from 47 percent in June 2005 to 35 percent in April 2007.[9] Despite an increase in total number of children in foster care during the past six months, percentage of children with the goal of adoption or guardianship slightly decreased (Table 2).

Figure E: Length of Stay of Children in District Foster Care, April 2007

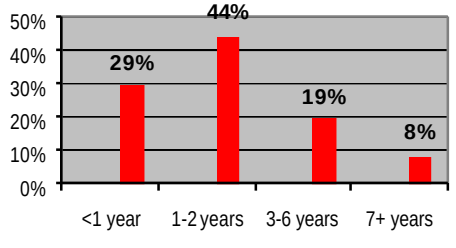


Table 2: Children with Goal of Adoption or Guardianship as Percentage of Total Foster Children Served

	Nov. 2006	April 2007
Total children served	2,355	2,413
Goal of adoption	538 (23%)	541 (22%)
Goal of guardianship	334 (14%)	295 (12%)

Source: FACES CMT252MM

[8] Source: FACES Management Report PLC107MS
[9] Source: FACES Management Report ADP047MM

From November 2006 through April 2007, CFSA moved 431 children to permanence (Table 3). Birth and extended families were the primary pathways, with more than half the children (58%) leaving foster care for reunification or guardianship. Sixty-one youth (14%) aged out of care.

Table 3: Reasons Children Exited Foster Care, November 2006-April 2007

Reunification	152 (35%)
Guardianship	96 (22%)
Emancipation	61 (14%)
Adoption	87 (20%)
Other	35 (8%)
Total children	431 (100%)

Sources: FACES PLC155MM

In May, ODPI completed a permanency trend analysis of children who exited CFSA care from Fiscal Years 2002 to 2006. The trend analysis, which CFSA has shared with the Court Monitor, reveals that the number/percent of children achieving adoption or guardianship increased during FY02-FY04 and declined during FY04-FY06. In contrast, number/percent of children achieving reunification declined FY02-FY04 and significantly increased FY04-FY06. Overall, percentage of children exiting care within 12 months of entry (with the majority of them achieving positive permanency outcomes) increased from 318 (33% of 953) in FY04 to 398 (39% of 1,025) in FY05. In addition, more than 30 percent of children were reunified or living with relatives within 90 days of entering foster care. While CFSA recognized the need for its permanency redesign, ODPI found additional factors relating to the recent decline in adoptions (from FY05 to FY06) are associated with several facts, such as the increase in children achieving reunification, decline in the total foster care population, and increase in the population of older youth in care.

Restructuring for Permanence: In January, CFSA launched a new collaborative model of permanency practice. Based in part on methods used in Tennessee, the model aims to achieve permanence for a greater number of children and youth more quickly. It establishes teams of ongoing and permanency social workers who partner to serve children and youth from out-of-home care entry through exit, regardless of changes in their permanency goals. CFSA's past practice was to transfer cases whenever a child's goal changed. Benefits of the new model include increasing social worker and agency focus on permanence from the outset of every foster care case; considering all pathways to permanence, particularly for the increasing number of older youth in foster care; improving concurrent planning to further reduce length of stay in care; eliminating disruptive and time-consuming case transfers in favor of building and sustaining relationships between social workers and their clients; and enhancing teamwork among social workers around all pathways to permanence.

In the spring, CFSA began reorganizing 24 units of social workers serving out-of-home cases in three case-carrying administrations to approximately 21-24 units in four administrations: In-Home & Reunification Services I and II, Office of Youth Development, and Permanency & Family Resources. CFSA disbanded most of its existing Adoption and Guardianship units and began to embed specialized permanency social workers in each out-of-home unit.

Implementation of the model is occurring in phases, which began in January and will end in summer 2007. The first phase, involving four out-of-home units in In-Home & Reunification Services and one unit in the Permanency and Family Resources Administration, was underway at the time of this report. CFSA has defined roles and responsibilities of permanency planning social workers, transferred their existing caseloads, and is developing business processes for the new units. The Office of Training Services developed a training curriculum focused on the

permanency redesign with special attention on teaming and case planning. Staff involved in the redesign's first phase began to receive this training in April. Currently, CFSA is recruiting permanency planning social workers for the second phase of implementation.

The QA Unit evaluated aspects of the new model, beginning with the planning and process development underlining it and including the implementation of training and development of business processes and outcome measures. To gather information, in March and April, QA interviewed more than 25 members of the implementation work group, conducted focus groups, and interviewed several representatives from Tennessee.

Based on the information gathered in the focus groups about the planning and implementation of phasing in the model, QA identified several strengths including: the implementation work group had representation from different administrations and worked as a cohesive team; members of the first phase of model implementation were able to articulate the theoretical reasons for the restructuring, such as expediting permanence and continuity of case management; and members of the first phase articulated that permanency planning social workers will be supportive of ongoing social workers' efforts to ensure that permanence receives attention at the very beginning of cases, will provide a second set of eyes on case planning and teaming, and will be helpful in identifying family resources.

In its evaluation of the planning and implementation of the model's first phase, QA also received feedback on several areas needing improvement. For example, before implementation of the first phase, CFSA did not have a business processes, specific measurable outcomes, a logic model, or clear roles and responsibilities. In addition, QA received feedback that CFSA should have clearly articulated the rationale for the new model by illustrating the agency's historic performance in all permanency outcomes.

Enhancing Resource Family Recruitment and Retention: In January, the Annie E. Casey Foundation contracted with a nationally recognized consultant to provide technical assistance to CFSA to enhance the recruitment and retention of foster parents. The consultant will review effective foster parent recruitment strategies used in other urban jurisdictions; hold community-based focus groups to gather information on both the public's and social workers' perceptions of the needs, challenges, and rewards associated with fostering and adopting; and analyze CFSA's statistics on foster parent recruitment from orientation through licensing. The consultant is also reviewing data from a survey of CFSA foster parents to determine their needs and the agency's effectiveness in meeting those needs. Upon reviewing the analysis of the data, the consultant will make agency-wide recommendations to develop and maintain a robust and quality pool of foster and adoptive parents.

In addition to the research and data analysis now underway, CFSA initiated a program to better serve those children who have had a permanency goal of adoption for an extended period of time (18 months or longer). Wendy's Wonderful Kids, through the Dave Thomas Foundation, awarded a one-year grant to CFSA to hire a specialized recruiter to recruit adoptive families for 15 children. Hired in late March, the recruiter will execute innovative strategies, such as nationwide recruitment efforts that use Web conferencing and video technology, to secure adoptive homes for those children.

In recognition that continued education and quality training of foster parents are vital to their retention, OTS is researching several strategies to work with CFSA's public and private partners to strengthen training and support of foster families. In April, OTS met with the Foster and Adoptive Parent Advocacy Center (FAPAC), Foster Parent Association, Adoptions Together, and Consortium for Child Welfare to develop short- and long-term goals to enhance the quality of training for foster parents.

Recommendations:

- *Evaluate the permanency redesign's effectiveness in achieving timely and appropriate permanency outcomes.*
- *Evaluate the effectiveness of adoptive recruitment efforts for children who have had an adoption goal for an extended period of time.*

Providing Youth-Driven Services to Youth 16 and Older

At the end of April 2007, youth age 16 and older made up 40 percent of the District's foster care population. CFSA's Office of Youth Development (OYD) serves youth age 16 and older with a permanency goal of Alternative Planned Permanent Living Arrangement (APPLA). In April 2007, OYD served 385 of the 832 youth in care with a goal of APPLA. Social workers in the In-Home & Reunification Administrations or in licensed child placement agencies served the remainder.

OYD intends to involve youth more consistently in their own case planning through Youth Connections Conferences. OYD and the Office of Clinical Practice (OCP) are currently developing the pilot to hold conferences for 16-year-olds, while management investigates options to increase staffing capacity to hold the conferences for all youth.

Through its partnership with the Collaboratives, OYD regularly holds Youth Connections Transition Conferences for 20-year-olds who are preparing to transition to independence. Thirty days before turning 20, CFSA and providers should refer all youth for Transition Conferences, which assist them with housing, employment, and other independent living needs. In April, CFSA and providers referred 21 youth for Transition Conferences.[10] OYD has not yet collected data on the outcomes of these conferences. Based on observations that private child placement agencies are inconsistently referring eligible youth to Transition Conferences, OYD is conducting additional training with the agencies.

In recognition of the best practice that permanency planning must continue for youth with a goal of APPLA, ODPI and OYD are investigating how to incorporate Family Finding into the agency's new permanency model. The Family Finding project identifies family members of older youth in care who may serve as life-long connections or provide permanent homes. Three

[10] Source: Office of Youth Development.

CFSA representatives attended train-the-trainer sessions with a national consultant and CFSA is exploring how to incorporate or develop this training into its existing curriculum.

OYD recently redesigned the Center of Keys to Life (CKL), a CFSA program that offers independent living skills training and educational and supportive services to youth up to age 21 in out-of-home care. Changes include engaging youth through a Youth Popular Culture program and a Youth Leadership Council. All OYD staff are now trained in a strengths-based youth development model that involves youth in decision-making. In April, 284 youth were enrolled in CKL.

CFSA has developed a taskforce of internal and external stakeholders, along with youth who identify as Lesbian, Gay, Bisexual, Transgender, Questioning and/or Intersexed (LGBTQI), to ascertain effective strategies for serving the LGBTQI population. In collaboration with the Child Welfare League of America and the Mayor's Office, the District is only the second "state" in the nation to develop and mandate LGBTQI training for its child welfare staff. CFSA will also track placements and replacements of LGBTQI youth to identify appropriate services for them.

Recommendation:

- *Collect and analyze data on the effectiveness of both types of Youth Connections Conferences.*

Taking Steps to Enhance Local Placement Resources

CFSA continues to strive to create a full continuum of local placement resources and services for children and youth. The AIP contains significant requirements to enhance placement capacity and stability. During the past six months, CFSA expanded and diversified capacity through contracts for placements for youth with serious emotional and behavioral problems and for older youth not yet ready to live independently but too old for traditional group homes. CFSA also solicited proposals to provide placements for children with serious medical and/or developmental disabilities. CFSA also completed an analytic study of adolescent girls who experienced multiple placements in foster care.

As of April 30, 2007, CFSA had 2,413 children in foster care.[11] Most of those children (1,688) were in family based foster care.[12] From January 1 through April 30, the Placement Services Administration (PSA) coordinated 432 placements: 160 initial placements, 231 replacements, and 24 respite care.[13] During the same period, PSA denied or delayed 90 replacement requests because CFSA had not held an FTM or implemented other services that might stabilize the placements. Although CFSA uses these strategies to ensure appropriate matching and to decrease

[11] Source: FACES Management Report CMT252MM.
[12] Source: FACES Management Report CMT232MM. This management report based the total foster care population as 2,377.
[13] Children with Confirmed Placements through the CFSA Placement Unit, CFSA Reconciliation Unit, May 31, 2007.

the number of preventable placement disruptions, staff are not consistently using the FTM process.

In June, CFSA launched Multidimensional Treatment Foster Care (MTFC) for youth between the ages of 13 and 17 with specialized behavioral needs. Twenty beds will be available to provide MTFC, with the goal of building on youth's strengths, decreasing antisocial behavior, and stabilizing youth in permanent homes.

CFSA will also have 16 Teen Bridge beds to assist youth, ages 16-21, with histories of abscondence and/or unsuccessful foster placements. These youth require a unique array of independent living and life skills, and support services. CFSA also solicited proposals to create 40 placements for medically fragile and/or developmentally disabled children and youth. CFSA recently completed the competitive Request for Proposal (RFP) process.

CFSA has maintained overall capacity of seven Stabilization and Replacement (STAR) emergency homes with the intention of having a total of 10 homes in July. STAR homes are available at any time of day or night as short-term (up to five days) placements for any child medically screened, regardless of age, gender, or behaviors. Children receive basic services while social workers assess their needs and placement staff matches them with appropriate, stable placements. CFSA's Office of Licensing and Monitoring has identified more than 30 District foster homes that may be prospective STAR homes. The Foster and Adoptive Parent Advocacy Center (FAPAC) has informed its members how to become a STAR home.

PSA continues to decrease the backlog of foster homes that Maryland has not approved under the Interstate Compact for the Placement of Children (ICPC). As of April 30, 2007, the backlog of unapproved ICPC placements in Maryland was 210, down from 241 in late October 2006.[14]

Placement Analysis of Female Adolescents: As of April 30, 2007, 528 children, or 22 percent of CFSA's total foster care population, had experienced three or more foster placements in the previous 12 months.[15] The AIP specifies several goals and action steps to reduce multiple placements, such as developing a work plan for creating a placement and service system to meet the needs of youth, convening an inter-agency summit to strategize to improve placement stability and permanency for youth, and expanding kinship placement resources. CFSA will also monitor case management practices among contracted private agencies.

To further understand the issue of multiple placements, Quality Assurance analyzed placements of female adolescents, age 15 and older, in foster care.[16] The analysis followed up on the 2006 multiple placement study by the Center for the Study of Social Policy (CSSP) and CFSA, which found that teen females had the highest rate of placement instability among all children who experienced multiple placements.[17]

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[14] Source: Program Supervisor, D.C. Interstate Compact on the Placement of Children, CFSA Placement Administration.

[15] Source: FACES Management Report PLC108.

[16] While the AIP required completion of a study of female adolescents ages 15-17, QA focused its analysis on females 15 years and older.

[17] "An Assessment of Multiple Placements for Children in Foster Care in the District of Columbia" available at http://www.cssp.org/major_initiatives/litigation.html

QA analyzed placements experienced by 10 randomly selected females who had three or more placements from September 1, 2005 to August 31, 2006. Using FACES as its primary source of information, QA examined a total of 47 placements experienced by the youth. Due to the small sample, the sample is not representative and the findings cannot be generalized. Most of the placements were in therapeutic foster care. As of August 31, 2006, most of the youth had a goal of Alternative Planned Permanent Living Arrangement.

QA identified both individual case practice and systemic factors that affect placement stability. Most placements were envisioned as stable (i.e., not short-term) arrangements and most appeared to be the least restrictive based on the youth's needs. A majority were appropriate to the type of permanency goal. However, youth were stable and receiving services to meet their needs in fewer than half the cases QA analyzed. Furthermore, fewer than half the placement moves were planned, meaning they resulted from a strategic decision to place the youth in a more appropriate setting or to expedite permanence.

During the review, QA identified issues about the recording of placement data and its accuracy. In a majority of the placements, QA found discrepancies between information in FACES placement screens and other documentation in FACES. QA also found that three of the 10 youth did not experience multiple placements during the review period.

As a result of the analysis, QA recommended that CFSA: (1) ensure planned placement changes based on strategic decisions that promote permanence, (2) ensure use of appropriate and comprehensive interventions to stabilize placements, (3) educate social workers about procedures for reporting placements and placement changes, and (4) audit the accuracy of placement information in FACES semi-annually.

Recommendation:

- *Implement quality improvement recommendations made in QA's analysis of placements experienced by female teens.*

Program Support

Initiatives to Improve Children's Well-Being

Office of Clinical Practice

CFSA's Office of Clinical Practice (OCP) launched several initiatives including preparing a Mental Health Needs Assessment, conducting "tests of change" to improve educational services

for foster children, developing crisis intervention services, and expanding dental care options for children and youth. Several challenges persist, particularly regarding accuracy of health-related data in FACES, creation of a mental and behavioral health services system, and referral of youth with CFSA and juvenile justice cases for FTMs.

Educational Updates: CFSA is working with the District of Columbia Public Schools (DCPS) to develop a Memorandum of Understanding (MOU) in response to a 2006 special education audit that the District's Inspector General conducted. It found that the two agencies did not account for children in CFSA custody who receive special education services or effectively share and record data about them. The MOU outlines strategies to improve information exchange between the agencies and to track data. CFSA is also assisting DCPS in developing a training program to enable foster parents to monitor the special education needs of children in their care and to make educational decisions on their behalf. Training is scheduled to begin by fall 2007. OCP management meets monthly with the DCPS Office of Special Education and Office of Student Residency to discuss systemic issues, cross-system collaboration, and any cases requiring immediate action.

CFSA and DCPS entered into a Truancy Initiative MOU to set guidelines for DCPS reporting of educational neglect allegations to the CFSA hotline.[18] This collaboration has proven effective in identifying instances of educational neglect—especially relating to truancy—and resulted in an increase in calls to the hotline and referrals of clients to the Collaboratives for services. DCPS has also placed an Attorney Advisor within the Family Court to assist with educational issues that arise during court hearings.

Casey Family Programs selected the District of Columbia as one of 10 jurisdictions to participate in its Breakthrough Series Collaborative (BSC) on *Improving Educational Continuity and School Stability for Children in Out-of-Home Care*. Adapted from the healthcare field, the BSC methodology is a quality improvement process that guides participating teams in addressing a specific child welfare practice challenge. Each team tests multiple ideas, strategies, and tools on a very small scale in its pilot site. As tests are concluded, team members immediately share results, make adjustments, and test again. At the conclusion of the BSC, the team should have substantive data on the effectiveness of a variety of practices.

The District's BSC team is composed of representatives from CFSA, DCPS, and Family Court, and birth and foster parents. The team has selected one school and one unit to conduct "tests of change" in two areas: (1) ensuring that CFSA has historical and/or current educational information for all school-age children entering foster care and (2) developing a structured mechanism to exchange information between DCPS and CFSA for children in out-of-home care.

In the BSC's initial phase, the team collected background information by conducting three focus groups with foster parents and foster youth to understand their perspectives on education issues, such as challenges associated with school enrollment, changing school placements, and accessing services that meet the youths' educational needs. The team also conducted 10 interviews with teachers working with youth in out-of-home care. The interviews gathered

[18] According to the 2007 CFSR Statewide Assessment Plan, in Calendar Year 2005, nearly 40% (672 out of 1,712) of all substantiated investigations completed by CFSA involved educational neglect issues.

information about the teachers' experiences in working with children in foster care and the level of teaming around education planning for the children.

Tests currently underway include examining educational assessments during Family Team Meetings and social worker collaboration with schools on children's special education needs. The D.C. team will analyze the test results, make refinements, and conduct additional testing on a larger number of cases. In fall 2007, the team anticipates issuing findings and recommendations on the most promising tools to apply on a broader scale to improve educational outcomes for children in foster care.

Mental Health Updates: At the request of the D.C. City Council and per an AIP requirement, CFSA and the D.C. Department of Health (DMH) prepared the initial draft of a Mental Health Needs Assessment to identify the mental and behavioral health needs of children and youth in out-of-home care. In 2005, responsibility for providing mental and behavioral health services to out-of-home clients shifted from CFSA to DMH.

The Needs Assessment found that in FY 2006, 2,688 individual mental and behavioral health service referrals were made for 1,387 CFSA child clients. Sixty-two percent (864) of children had at least one court-ordered service referral. The most frequently used services were individual therapy, family therapy, mentoring, and medical services. Clients ages 12 to 17 required the most services. Although the most prevalent disorders were behavioral and emotional, such as Attention Deficit Disorder with Hyperactivity Disorder (ADHD), depression, anti-social disorder, and adjustment disorder, children had a wide range of diagnoses and needs. Most children had more than one mental health diagnosis.

The Needs Assessment identifies client service use, evaluates the current service array and accessibility of or barriers to services, recommends ways to enhance collaboration between DMH and CFSA, and proposes strategies to evaluate private and public provider service delivery systems. It recommends that the two agencies:

- Develop an information management process and research agenda concerning mental and behavioral health needs and services.

- Create a multi-agency system of mental and behavioral health services funded by both Medicaid and non-Medicaid resources.

- Develop a collaborative assessment and action plan to improve mental and behavioral health services to children in care.

- Assess CFSA expenditures of local dollars for mental and behavioral health services and enhance alternative services available through local funding.

In April, CFSA and DMH submitted a draft of the Needs Assessment to the Court Monitor. The agencies are currently writing a section that identifies next steps. Following approval of the Needs Assessment, the agencies will prepare a Request for Proposals (RFP) to establish a consolidated network of priority providers that will furnish Medicaid and non-Medicaid covered

services to CFSA clients. The creation of such a network will correct a historically fragmented mental and behavioral health service system and will be designed to serve CFSA's dual client populations of in-home and out-of-home families.

To ensure that children who have experienced placement instability or psychiatric hospitalization receive timely mental health services, DMH revised the authorization policy for community-based intervention (CBI) services. CBI services are designed to stabilize children in foster care, as well as transition children back into their communities and homes and meet their emotional and behavioral needs as they leave institutional care. Children who experience two or more foster care placements in a 12-month period and children who are being discharged from a psychiatric hospitalization no longer require preauthorization for CBI services.

The privately run Hurt Home, the District's only residential treatment facility for young children, closed in December 2005. The AIP requires DMH to secure an alternative provider of residential services for children 6 to 12 and for other specialized day programming. CFSA and DMH have partnered to ensure those services remain available in the District. In February, DMH issued a Request for Proposals with a mid-April submission deadline. The evaluation concluded and a single applicant was rejected.

In response to the AIP mandate to make crisis intervention services available to children and families, OCP is developing a resource to provide in-home behavioral management support services to birth and foster parents and short-term (not to exceed five days) respite homes. Crisis intervention services will assist families in developing skills to address behavioral challenges, resolve family conflicts, and prevent foster placements from disrupting. CFSA is also developing crisis respite foster beds linked with behavioral management services. OCP anticipates conducting a full solicitation this summer for the behavior management services. In April, crisis services through the Mobile Urgent Response Team became available to District and Maryland families served by CFSA. The AIP stipulates that CFSA's crisis intervention services program be operational for FY 2008.

Family Team Meeting Update: From January 1, 2007 to April 30, 2007, CFSA conducted 174 FTMS (Table 4).

Table 4: Family Team Meetings, January 1-April 30, 2007

Removal FTMs	59
Placement FTMs	61
At-Risk-of-Removal FTMs	36
Other FTMS	18
Total FTMs	174
Total children: 276 Total family members:560	

The FTM Unit is reconfiguring FTMs to strengthen teaming between CFSA social workers and families. Since introducing FTMs in 2005, FTM coordinators and facilitators—non-case-carrying professionals—have been solely responsible for engaging team members, scheduling FTMs, and facilitating discussions with the family team. In the initial design of FTMs, the social worker's role was only to provide background case history to the coordinator and attend the meeting. However, since adoption of the Practice Model that emphasizes teaming as a cornerstone of quality child welfare practice, the FTM Unit is restructuring to pairing of the social worker and facilitator. In this partnership, FTM staff will model skills to widen and engage the family's support system; social workers will, in turn, mirror those skills in their daily work with families.

The FTM Unit is testing several strategies to facilitate greater family and social worker participation. Per the AIP, their full implementation must occur by the end of 2007.

- **For removal FTMs** that occur when CFSA removes a child from home, the FTM Unit has proposed a series of FTMs and Family Group Conferences (FGC)[19] at three critical junctures: (1) an FTM within two days of the child's entry into foster care, (2) an FGC when the child has been in care for 90 days, and (3) an FGC at nine months in care. These meeting points are critical times when the social worker is working with the family on case planning and planning for Administrative Reviews and the Permanency Planning court hearing. Serialized family meetings will build and reinforce the collaborative family-social worker relationship, ensure that a team of family members and professionals is fully formed and functional, and push the team to continually address permanency decisions. To monitor that families receive services identified in the meetings and that families and professionals progress in accomplishing case plan goals, the meetings will also inform and track case planning and service delivery.

- **For placement FTMs** that occur when CFSA removes—or is likely to remove—a child from a foster placement, the FTM Unit is considering a model whereby the social worker coordinates with the FTM facilitator to share information about the child's family, work with the family to identify sources of support who should be invited to the meeting, increase the family's understanding of the purpose of the FTM, and empower the family to share in decision-making and to articulate strengths, needs, and goals.

In 2006, CFSA and the D.C. Department of Youth Rehabilitation Services (DYRS) agreed that CFSA would conduct FTMs for youth with "dual jackets" (open cases with both CFSA and DYRS). CFSA agreed to hold FTMs for youth detained at the Youth Services Center and for those with a risk score that indicates they can be safely released to the community. Since December 2006, social workers have not referred any youth with dual jackets for FTMs. To develop procedures for information exchange and an effective referral process, CFSA representatives are holding discussions with DYRS and Court Social Services. CFSA leadership is also exploring internal procedures and accountability measures to guarantee that the dual-jacket FTM referrals occur.

Health Services: The AIP requires CFSA to execute a new contract to operate the DCKIDS program, which provides health and developmental health services to children and youth in foster care. CFSA has negotiated a new contract with Children's National Medical Center (CNMC) with final approval expected by late June. The new contract features several quality improvements, including:

[19] According to CFSA's FTM Program Manager, FTMs and FGCs differ in two principle ways. FTMs use a structured agenda and require all participants to remain in the same room during the duration of the meeting. FGCs, on the other hand, use a less structured agenda and allocate private time to family members so they can discuss among themselves the family's needs and goals and develop a plan of action to present to the team. The team then offers feedback on the family's plan, identifies any unaddressed needs, describes services, and clarifies CFSA's concerns and how the parties can work together to address those concerns.

- Prompt pre-placement medical and behavioral screenings and 30-day comprehensive evaluations at a community-based clinic.
- Coordination of medical, dental, vision, nutritional, and developmental health services.
- Health professionals who understand child welfare.
- Quarterly roundtable meetings with external stakeholders and customer satisfaction surveys to assess provider performance.

Several provisions of the contract have already begun, including use of THEARC as the community-based clinic. Effective May 1, social workers began taking children to THEARC, a state-of-the art facility in Ward 8, for screenings needed during the day. Screenings after hours and on holidays continue at CNMC's main campus. CFSA anticipates that the consolidation of screenings and evaluations at the THEARC will improve ability to track, monitor, and report on health care services received by children in care.

Health Services expanded dental services to CFSA children and youth, fulfilling an AIP action step. In February, oral health services through the Small Smiles Dental Clinic became available to children with Medicaid or D.C. Healthy Families coverage. Operating clinics in the District and Maryland, Small Smiles provides routine and some specialty dental services to children from "first tooth" through age 20, including dental certificates for school enrollment.

CFSA also partnered with Gentle Dental Care's Dentistry on Wheels, a mobile van featuring state-of-the-art equipment and dental professionals who provide affordable, on-site screenings, detection, and treatment for children and youth. Health Services is holding discussions with Gentle Dental Care to establish a regular schedule for the mobile van to visit CFSA's main office to serve CFSA children and youth.

CFSA is mandated to ensure that every child in or entering foster care receives a health screening before placement or replacement. CFSA was required to achieve full compliance with this standard by December 31, 2006. Capturing accurate health-related data in FACES continues to be an issue, with the Health Services Administration relying on manual data from DC KIDS and comparing it to information at CFSA to measure performance. However, due to insufficient capacity in Health Services to reconcile health screening data between DC KIDS and FACES, Health Services is unable to analyze and monitor performance monthly. At the time of this report, Health Services could furnish reconciled data for January. Data indicate that all 44 children who experienced initial placements received health screenings. Of the 78 children who experienced replacements, 51 (65%) received screenings. Health Services has provided information to the program areas for feedback; the program areas initially responded that screenings are taking place, but they would look into the instances where children were missing a screening. Health Services has not yet received feedback from the program areas.

In compliance with the federal Child Abuse Prevention and Treatment Act, CFSA has signed an MOU with the D.C. Department of Human Services, Early Care and Education Administration to provide CFSA foster children with early intervention services at Howard University's Child Development Clinic. The MOU stipulates that children from birth to age three involved in a substantiated case of abuse/neglect and who have developmental needs will receive comprehensive evaluations.

Recommendations:

- *Evaluate the Truancy Initiative's effectiveness in reporting and referring educational neglect cases.*
- *Establish capacity to analyze health screening data from FACES and DCKIDS to determine accuracy, trends, and agency compliance against performance measures.*
- *Inform social workers of procedures to refer youth with dual-jackets for FTMs and tighten supervisory oversight to ensure the referrals occur.*

Observations Identify Administrative Review Strengths and Challenges

The Administrative Review Unit continues to sustain a high rate of performance, with 99% of children receiving a timely Administrative Review in the first four months of 2007.[20]

To enhance the Administrative Review process, Quality Assurance observed five reviews in April 2007. Due to the size of the sample, the sample is not representative and the findings cannot be generalized. QA's objective was to assess the quality of discussions in promoting safety, well-being, and permanence for children and youth in foster care.

QA found reviewers encouraged attendees to participate in discussions, ask questions, and provide feedback; discussion about child well-being generally occurred in all the reviews; and most reviews identified the child's permanency goal. Areas needing improvement included: ensuring comprehensive discussion about the child's safety, including at home, at school, and in the community; detailing immediate next steps—along with deadlines—to move the child to permanence; and discussing the quality of visits and effectiveness of services.

QA presented findings and recommendations from its assessment to Administrative Review managers and staff. Next steps are to develop and implement strategies to improve the consistency and quality of discussions in reviews.

Recommendation:

- *Conduct periodic observation studies to provide feedback on the quality of the Administrative Review process.*

QSRs Stimulate Continuous Learning and Practice Improvement

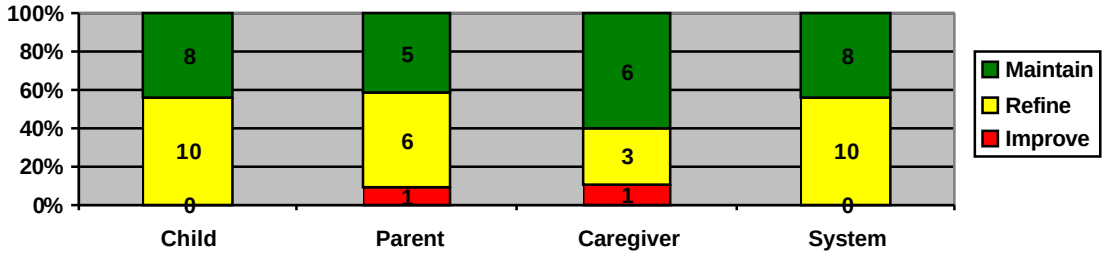
In January, the Quality Service Review (QSR) Unit began piloting a unit-based QSR model to cultivate unit-by-unit continuous learning and case practice improvement. In this model, reviewers select one case per social worker in the targeted unit for review. After QSR specialists interview stakeholders, the unit participates in a case staffing to discuss creative ways to address

[20] Source: FACES Management Report RVW001

barriers or challenges, and the social workers and QSR specialists agree on next steps to take in each case. Two months later, QSR specialists follow-up with social workers to determine the status of the recommendations.

The pilot took place in February through April with three units participating. Following the pilot, the QSR Unit is randomly selecting units from each case-carrying administration on a rotating basis. They reviewed 18 cases from February to May (Figure F).[21] So far, unit-based QSRs have found that social workers were often forming good relationships with families and usually had a comprehensive understanding of their cases. In most instances, social workers followed recommended next steps and achieved positive results. A challenge on some in-home cases was connecting families to informal supports. For out-of-home cases, biological family members, including parents, were not always as involved as they could have been.

Figure F: Overall Status: February - May 2007 QSRS



The QSR Unit will prepare an annual report by the end of FY 2007. In fall 2007, the unit will also review cases private agencies are managing. QSR staff will share the annual report, as well as case stories and data from the unit-based and private agency reviews, with the agency, community members, and other stakeholders at a large, grand rounds-style meeting in October.

[21] "Child status" encompasses safety, well-being, and school performance of the child. "Parent" and "Caregiver" status illustrate the quality of support of the child, their participation in the case, and progress to case closure. "System status" means the quality of case practice in engagement, leadership, teaming, assessment, case planning, and case plan implementation. The QSR rates findings in three zones: "Maintenance" (green) means things are going well and should continue. "Refinement" (yellow) indicates a need to address some problems. "Improvement" (red) indicates a pressing need for immediate corrective action.

Administration

CFSA Prepares for Performance-Based Contracting

CFSA in accordance with the *LaShawn* Implementation Plan and the AIP has been planning a performance-based contracting (PBC) system as one strategy for improving outcomes for children and families. PBC is a method of contracting that links financial payment to performance. Through PBC, CFSA seeks to increase the rate and timeliness of permanence through reunification, adoption, or guardianship; increase the number, range, and diversity of placement settings; increase placement stability; and enhance practice innovation by encouraging swift and creative responses to family and child needs. In February 2007, CFSA began using provider performance to calculate certain payments under current family-based care contracts.

CFSA's target population is children in out-of-home care. In October 2006, CFSA released a Request for Information (RFI) detailing a proposed model for PBC, including financial incentives and performance requirements and goals. As a result of feedback on the RFI, CFSA re-engaged the community, including current service providers, non-contracted providers, and non-local participants, through a series of five meetings to seek agreement on shared performance expectations for the District's child welfare system. Those meetings occurred in March and April 2007. CFSA is analyzing information from the meetings and plans to release a Request for Proposals for PBC in summer 2007. The anticipated contract start date is February 1, 2008.

Quality Recommendations

Agency-Wide Recommendations

CFSA continues to make significant progress in strengthening the safety net for abused and neglected children and youth in the District of Columbia. To become a fully functioning, data-driven child welfare system that is rooted in shared accountability, self-monitoring, and information exchange, CFSA must maintain performance progress and build a system of continuous quality improvement. CFSA must rapidly move beyond focusing primarily on compliance with court-imposed mandates to also changing the organizational culture to ensure quality practice and services. CFSA must also carry out the following specific steps to keep children safe and healthy and move them to permanence.

- Incorporate family-centered practices in all aspects of in-home and out-of-home practice, develop and implement mechanisms to measure family involvement in case planning and other areas of case practice, and assess stakeholders' satisfaction with those practices.

- In partnership with the D.C. Department of Mental Health, create a multi-agency system of mental and behavioral health services and providers that will deliver both Medicaid and non-Medicaid funded services to CFSA clients.

- Establish and include in planning and development a viable, well-trained, and fully supported network of foster and adoptive families who meet the diverse needs of children and youth in CFSA's care.

- Conduct ongoing evaluation of the effectiveness of the new permanency model in reducing time in foster care and in quickly achieving permanent homes for children and youth. ¡